STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED	
		155095	B. WING		01/13/2012
				ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	PROVIDER OR SUPPLIE	R		OBSON RD	
HERITAG	GE PARK			VAYNE, IN46805	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0000					
	This visit was fo	or a Recertification and	F0000	The creation and submission	
	State Licensure	Survey.		this Plan of Correction does constitute an admission by the	
	Survey dates: January 9, 10, 11, 12 & 13, 2012			provider of any conclusion so forth in the statement of deficiencies, or of any violati regulation.This provider	on of
	Facility number	: 000038		respectfully requests that the	;
	Provider numbe			2567L Plan of Correction be	diblo
	AIM number: 1			considered the Letter of Cred Allegation.Based on past sui	
	711VI Hullioci . 1002/1030			history and no harm identifie	-
	Survey team:			any resident; this facility	
	Angela Strass R	N TC		respectfully requests a desk review in lieu of a post-surve	AV.
	Sue Brooker RI)		revisit on or after February 1	-
	Rick Blain RN			2012.	,
	Diane Nilson, R	N			
	Diane Wilson, N				
	Census bed type	2:			
	SNF/NF: 151				
	SNF: 29				
	Total: 180				
	Canqua mayyar to	mo:			
	Census payor ty				
	Medicare: 28				
	Medicaid: 95				
	Other: 45				
	Total: 180				
	Stage 2 sample:	40			
		ies also reflect state accordance with 410 IAC			
LABORATOR	L RY DIRECTOR'S OR PRO	OVIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURE	TITLE	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

4Y9211

Facility ID:

If continuation sheet

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	A. BUILDING	LE CONSTRUC 00	TION	(X3) DATE S COMPL 01/13/20	ETED
NAME OF P	ROVIDER OR SUPPLIER		B. WING OTT 13/2012 STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN46805				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAC	CROSS	PROVIDER'S PLAN OF CORRECTION CH CORRECTIVE ACTION SHOULD BE S-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0253 SS=E	Quality review of Cathy Emswiller The facility must property as an itary, orderly Based on obserecord review, assure 4 grab to were firmly second the facility. Finding include 1. During the enthe facility, began 1/12/12, and an Maintenance Some Maintenance And were observed: The grab bars of following resides	rovide housekeeping and ices necessary to maintain, and comfortable interior. rvation, interview, and the facility failed to pars over the toilet ured in 4 resident of 9 resident hallways s: environmental tour of ginning at 9:40 a.m. on ecompanied by the upervisor, and the ssistant, the following entrooms were loose and wobbly; the 200 unit; the 600 unit;	F0253	F253 MAII the pensumair provemair com base prace imple actic those beer prace bars tight bars tight bars will y havi by th	3- HOUSEKEEPING & NTENANCE SERVICESI practice of this provider to ure housekeeping and ntenance services are rided as necessary to ntain a sanitary, orderly a fortable interior. Howeve ed on the alleged deficier tice the following has bee mented:What corrective on(s) will be accomplishe e residents found to have n affected by the deficien tice:Room 210 The grab have been ened.Room 602 The grab have been ened.Room 701 The grab have been ened.Room 800 The grab have been tightened.Ho you identify other residen ng the potential to be affen en same deficient practice what corrective action wi	ab www.ts.ected	02/10/2012
	Room 800 on	•		foun	n:No other residents wer d to have been affected alleged deficient		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155095		(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE : COMPL		
				LDING		01/13/2	
		100000	B. WIN			01/10/2	012
NAME OF I	PROVIDER OR SUPPLIEF	3			ADDRESS, CITY, STATE, ZIP CODE		
HERITAG	GE PARK				OBSON RD VAYNE, IN46805		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID			(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	IE	DATE
	During interviev	w at that time, the			practice.Residents living in the		
	Maintenance S	Supervisor indicated no			facility requiring the use of gi		
		ed the loose grab bars			bars over their toilet have the potential to be affected. The)	
	over the toilets	, and indicated they			Maintenance Department		
	needed to be ti	-			performed a whole house au	dit	
					on 1/12/12 to ensure all bars		
	Review of the I	Daily Maintenance			were secure.Housekeeping a	and	
	Policy, provide	d by the Administrator			Maintenance staff has been		
	at 12:07 p.m. o	n 1/13/12, indicated as			re-educated on assessing stablility of grab bars. Educa	tion	
	areas needing	repair or attention were			includes but is not limited to		
	identified, they should be dealt with				housekeepers checking the		
	immediately. If	f that was not possible,			stability of the bars daily duri	ng	
	the issue and t	he area and/or resident			routine cleaning rounds and		
	room number s	should be recorded for			notifying the Maintenance Director of concerns. The		
	proper follow-u	p.			Maintenance Department ch	ecks	
					the bars monthly and provide		
	3.1-18(a)				documentation of rounds in t	he	
	3.1-19(f)				Preventative Maintenance		
	()				Log.Education provided Janu 12-25, 2012 by the Maintena		
					Director.The Maintenance	IICE	
					Director is responsible to ens	sure	
					compliance.What measures		
					be put into place or what sys		
					changes you will make to en that the deficient practice do		
					not recur:Residents living in		
					facility requiring the use of gi		
					bars over their toilet have the		
					potential to be affected. The		
					Maintenance Department performed a whole house au	dit	
					on 1/12/12 to ensure all bars		
					were secure.Housekeeping a		
					Maintenance staff has been		
					re-educated on assessing		
					stablility of grab bars. Educa	tion	
					includes but is not limited to housekeepers checking the		
					Housekeepers Checking the		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CO A. BUILDING B. WING	00		e survey Pleted '2012		
NAME OF P	PROVIDER OR SUPPLIER	<u>l</u>	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN46805					
(X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE		
				stability of the bars routine cleaning routine cleaning routine cleaning routine cleaning routine cleaning routine december of concern Maintenance Department of the bars monthly a documentation of Preventative Maint Log.Education pro 12-25, 2012 by the Director.The Maint Director is respons compliance.How the action(s) will be mensure the deficien not recur:A CQI mensure the deficien not recurs. Data will be developed.Non-confacility procedure redisciplinary action including terminati Date: February 10	s daily during bunds and tenance ins. The artment checks and provides rounds in the tenance ovided January in Maintenance tenance is ble to ensure the corrective onitored to interactive onitoring tool ecurity" will be in the submitted the interaction of the submitted			
FORM CMS-2	567(02-99) Previous Version	ons Obsolete Event ID:	4Y9211 Facility	ID: 000038 If	continuation sheet P	age 4 of 9		

		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155095	A. BUILDING 00 COMPLETE 01/13/2012		(X3) DATE SURVEY COMPLETED 01/13/2012		
		100000	B. WING		01/13/2012		
NAME OF P	ROVIDER OR SUPPLIER SE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN46805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE		
F0431 SS=E	The facility must e of a licensed phan system of records all controlled drugs enable an accurate determines that drugs that an account of maintained and per programmers of the appropriate accepted profession the appropriate accinstructions, and the applicable. In accordance with the facility must strin locked comparts temperature control authorized person keys. The facility must profession permanently affixed of controlled drugs Comprehensive D Control Act of 197 abuse, except who unit package drug which the quantity missing dose can	mploy or obtain the services macist who establishes a of receipt and disposition of in sufficient detail to e reconciliation; and ug records are in order and all controlled drugs is eriodically reconciled. cals used in the facility must redance with currently onal principles, and include cessory and cautionary he expiration date when a State and Federal laws, ore all drugs and biologicals ments under proper ols, and permit only hel to have access to the rovide separately locked, and compartments for storage is listed in Schedule II of the rug Abuse Prevention and 6 and other drugs subject to en the facility uses single distribution systems in stored is minimal and a be readily detected. rvation, interview, and	F0431	F431 DRUG RECORDS,	02/10/2012		
	record review, to ensure the tem medication refrimaintained between the degrees F (Fahra medication refrired).	the facility failed to perature of 1	1 0731	LABEL/STORE DRUGS & BIOLOGICALSIt is the practi this provider to store all drug biologicals in locked compartments under proper temperature controls, and pe only authorized personnel to access to the keys. However based on the alleged deficier	ce of s and ermit have		

STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	CTION (X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A DIM DDG	00	COMP	COMPLETED	
		155095	A. BUILDING		01/13/2	2012	
		<u> </u>	B. WING	EET ADDRESS CITY STATE ZIN CON			
NAME OF I	PROVIDER OR SUPPLIE	R		EET ADDRESS, CITY, STATE, ZIP COD	E		
LIEDITA				1 HOBSON RD			
HERITA	HERITAGE PARK			RT WAYNE, IN46805			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL		PREFIX	PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)	TAG			DATE	
	residents with	medications stored in		practice; the following ha			
	the refrigerator	(Residents #6, #7,		implemented:What corre			
	_	74, #181, and #207).		action(s) will be accomp			
		., , /.		those residents found to			
	Findings include:			been affected by the def			
				practice:Resident #130 medication was dispose			
				new medication was	u oi ailu a		
	During a tour of	•		ordered/received.Reside	ent #7		
	medication sto	rage areas with LPN #2		The medication was disp			
	on 1/11/2012 a	at 9:00 A.M., the		and a new medication w			
	thermometer in the medication			ordered/received.Reside	ent #6		
	refrigerator in the South Unit			The medication was disp	oosed of		
	medication room indicated the			and a new medication w			
				ordered/received.Reside			
	1	side the refrigerator		The medication was disp			
	_	es F. LPN #2 obtained		and a new medication w			
	_	nermometer from		ordered/received.Reside			
	Dietary Service	es and placed it into the		The medication was displand a new medication w			
	refrigerator. A	t 9:45 A.M. the new		ordered/received.Reside			
	thermometer in	ndicated the		The medication was disp			
	temperature in	the refrigerator was		and a new medication w			
	1	s F. During an		ordered/received.Reside			
	_	LPN #2 at that time,		The medication was disp	oosed of		
		-		and a new medication w	as		
		ted the medication		ordered/received.How w	•		
	•	ere to be checked daily		identify other residents h	-		
	by nursing state	ff. LPN #2 also		potential to be affected to			
	indicated the n	nedications in the		same deficient practice			
	refrigerator wo	uld need to be		corrective action will be other residents were fou			
	_	a different refrigerator		have been affected by the			
		ed into the medication		deficient practice.Reside	•		
	room.	Ta mile and medicalien		requiring refrigerated me			
	100111.			have the potential to be			
	A 4	lan fan tha cost die C		by the alleged deficient			
	•	log for the medication		practice.Licensed staff h	as been		
		the South Unit for		re-educated on the stora			
	January 2012	indicated the		refrigerated medication.			
	temperature w	as checked daily and		Education includes but i	s not		
		,		limited to licensed nurse	s		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIE		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
155005		B. WING 01/13/2012				012	
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	R			OBSON RD		
HERITA	HERITAGE PARK				VAYNE, IN46805		
				<u> </u>	, , , , , , , , , , , , , , , , , , ,		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	-	ecorded as 40 degrees			checking the temperature of medication refrigerators daily		
		cept on 1/4/12 when			appropriate temperature	/, tile	
	the temperatur	e was recorded as 38			expectations and reporting		
	degrees F. Th	e log indicated the			concerns immediately to the		
	refrigerator ten	nperature had not been			Director of Nursing Services	The	
	checked on 1/2	-			3rd shift nurse checks the		
					temperature of the medication		
	The following r	medications were			refrigerator and documents t		
	_	e in the medication			reading on the Temperature		
					Sheet nightly.Education prov	rided	
	_	the South Unit on			January 12-25, 2012 by the Director of Nursing Services.	The	
	1/11/2012 at 9	:00 A.M.:			Licensed Unit Managers are	THE	
					responsible to ensure		
	Resident #130	: One unopened vial of			compliance.What measures	will	
	Novolog insulir	n (injectable medication			be put into place or what sys		
	used to treat d	iabetes). A label on the			changes you will make to en		
	insulin indicate	ed it was to be kept			that the deficient practice do		
	refrigerated.	•			not recur:Licensed staff has		
					re-educated on the storage of	DΤ	
	Resident #7: C	one unopened bottle of			refrigerated medication. Education includes but is not	+	
		al spray (medication			limited to licensed nurses		
		steoporosis). A label on			checking the temperature of	the	
		•			medication refrigerators daily		
		ndicated it was to be			appropriate temperature		
	kept refrigerate	ea.			expectations and reporting		
					concerns immediately to the	Tl	
		wo unopened bottles of			Director of Nursing Services 3rd shift nurse checks the	ine	
	lorazepam liqu	id sublingual drops			temperature of the medication	'n	
	(medication us	ed to treat anxiety and			refrigerator and documents t		
	to be placed ui	nder the tongue). A			reading on the Temperature		
		razepam indicated it			Sheet nightly.Education prov		
	was to be kept refrigerated.				January 12-25, 2012 by the		
		3			Director of Nursing Services		
	Resident #121	: One unopened vial of			Licensed Unit Managers are		
		n (injectable medication			responsible to ensure		
	_				compliance. How the correcti		
		iabetes). A label on the			action(s) will be monitored to ensure the deficient practice		
	insulin indicate	ed it was to be kept			chaute the delicient practice	vVIII	

STATEMENT OF DEFICIENCIES X1)		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING 00		00	COMPLETED	
		155095	A. BUILDING B. WING 01/13/2012			012	
		1	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			OBSON RD		
HEDITA	GE PARK				VAYNE, IN46805		
	JE I AIN			TOKTV	VATNE, IN40003		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	refrigerated.				not recur:A CQI monitoring to		
					titled "Refrigerated Medication		
	Resident #174	: One unopened box of			Storage" will be utilized ever week x 4, monthly x 3 and	у	
	Forteo syringes	s (injectable medication			quarterly thereafter for		
		steoporosis). A label on			6-months.Data will be submi	tted	
		ed the Forteo syringes			to the CQI committee. If 95%		
	were to be kep	, ,			threshold is not met, an action		
	word to be kep	t reingerateu.			plan will be		
	Posidont #02:	One unopened box of			developed.Non-compliance		
		•			facility procedure may result	ın	
		s. A label on the box			disciplinary action up to and including termination.Comple	otion	
		orteo syringes were to			Date: February 10, 2012.	HION	
	be kept refrige	rated.			Date: 1 editiary 10, 2012.		
	Resident #207	: One unopened					
	package of Ris	perdal Consta syringes					
	(injectable med	dication used to treat					
	1 ` -	orders). A label on the					
	1 . ,	ated the Risperdal					
		es were to be kept					
		ss were to be kept					
	refrigerated.						
	The 6- 221 B	t f Ni in					
		ector of Nursing					
		mation on storing					
	· ·	hich was obtained from					
	the pharmacy,	on 1/11/2012 at 11:00					
	A.M. The infor	mation indicated the					
	Novolog insulir	n and humalog insulin					
	_	frigerated until opened.					
	The information	-					
	calcitonin nasal spray was to be kept						
	refrigerated until opened. The information indicated the lorazepam						
		•					
		os were to be kept					
	_	ne information indicated					
	the Forteo syri	nges and Risperdal					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA I OF CORRECTION IDENTIFICATION NUMBER: 155095	(X2) MULTIPLE CO A. BUILDING B. WING	00	— COM 01/13	TE SURVEY MPLETED 3/2012	
	PROVIDER OR SUPPLIER GE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2001 HOBSON RD FORT WAYNE, IN46805				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
	Consta syringes were to be kept refrigerated.					
	A policy entitled "Storage and Maintenance of Medications", with a revision date of 7/20/11, was provided by the Director of Nursing Services on 1/11/12 at 9:50 A.M. The policy indicated "The refrigerator must maintain a proper temperature of 36 - 46 degrees F" 3.1-25(m)					